



# Innovative Strategies for VCT PHRU experience

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## HIV testing models:

Mandatory

Routine

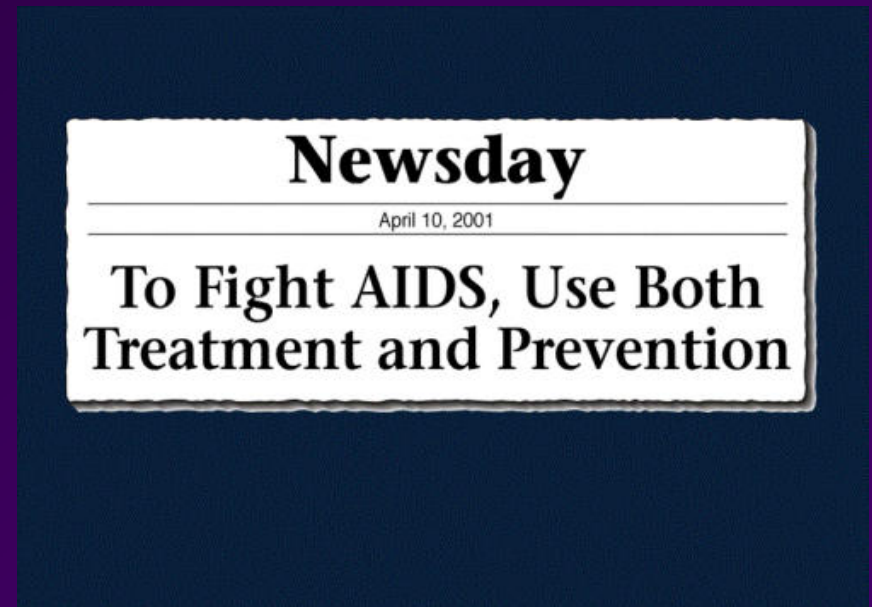
VCT

Diagnostic



# Prevention and care in Africa needs a sero-status based approach

- Universal voluntary knowledge of sero-status
- Simplified clinical testing



# HIV testing

- Mandatory
- VCT for prevention
- Routine testing for delivery of specific preventive health care interventions
- Diagnostic testing in the context of individual medical care



# What is the structure of VCT?



- Brief and focused
- “client focused”: focus on the client’s unique issues and circumstances related to HIV risk
- Based on a risk reduction model: designed to reduce not necessarily eliminate risk

# Principal Components of the VCT protocol

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## Initial Intervention Session:

- *Introduction and Orientation to the session*
- *Assess risk*
- *Explore Options for reducing Risk*
- *HIV test Preparation*



# Principal Components of the VCT protocol

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## Second Intervention Session: *Client with HIV- result*

- Provide HIV- result
- Negotiate risk reduction plan
- Identify support for risk reduction
- Negotiate disclosure and partner referral

# Principal Components of the VCT protocol

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## Second Intervention Session: *Client with HIV + result*

- Provide HIV + result
- Identify Sources of support
- Negotiate disclosure and partner referral
- Address risk reduction issues



# VCT services offered by PHRU

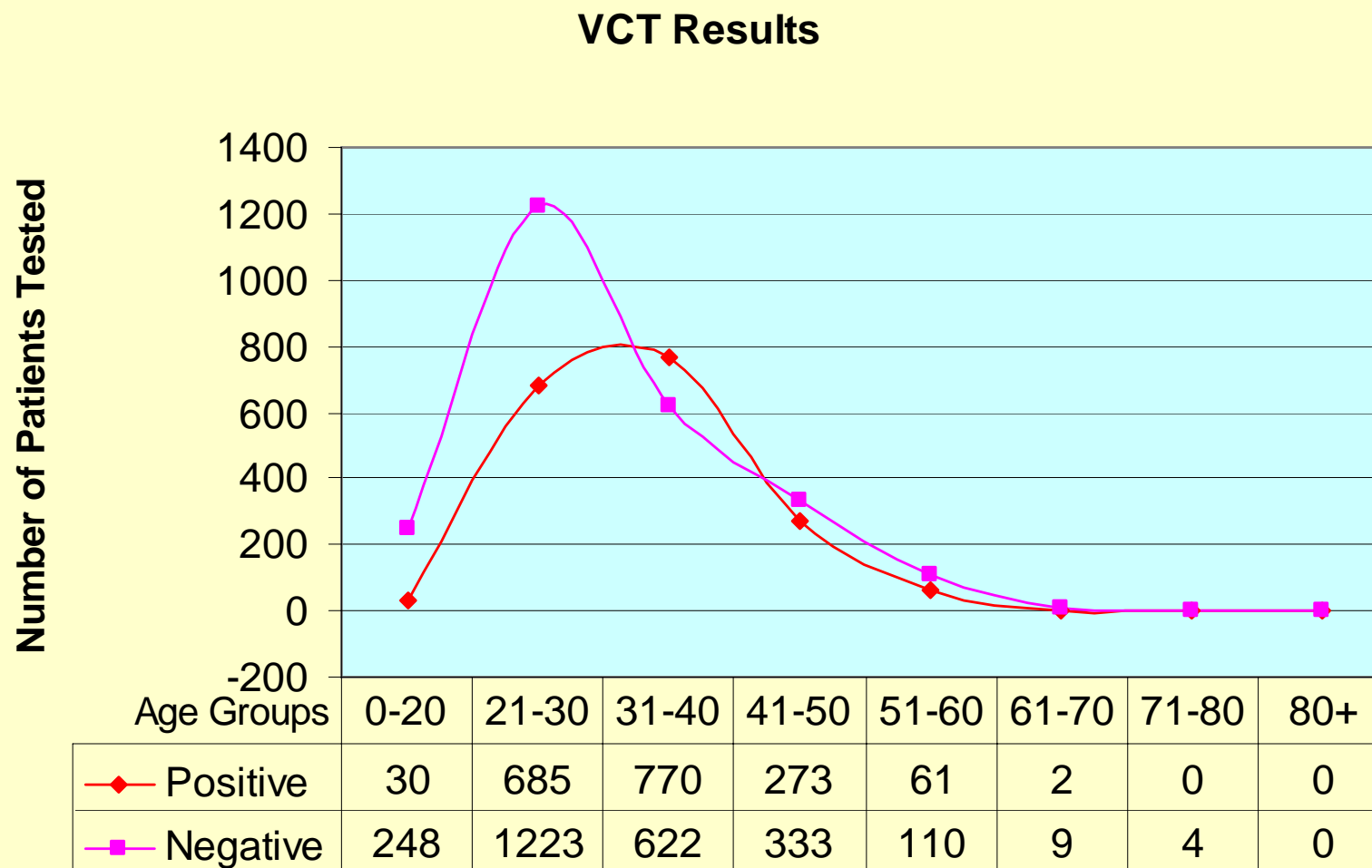
- PMTCT: 30 000 women/year (125 per day)
- PPVCT: 150 women/month (8 per day)
- Couple Counselling established in April 2004 (Tswarisanang) 60 couples pm (3 per day)
- Mobile VCT: 130 pm (7 per day)
- Stand alone VCT: 360 pm (18 per day)
- Adolescent VCT established in Nov (1 per day)

# Attracting men

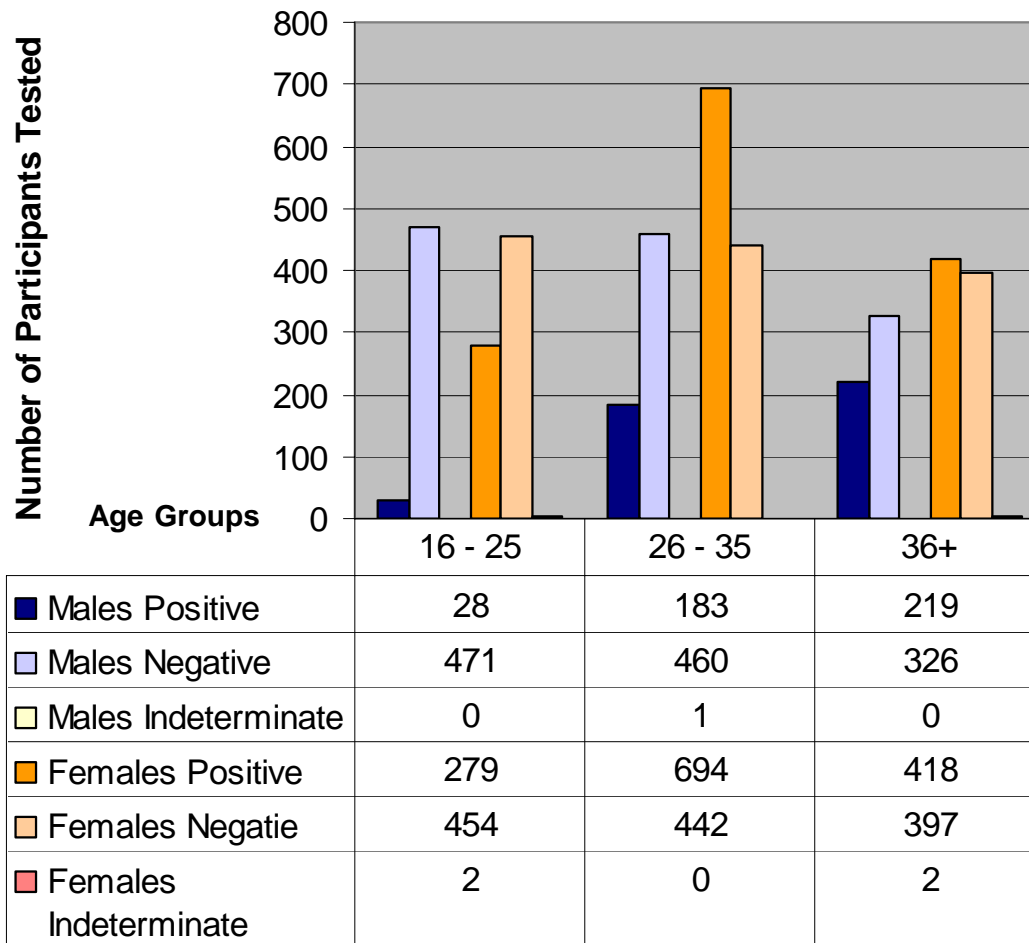
- 40% of VCT attendees in vaccine division are men
- Mobile VCT: 61% are men
- Couples Counselling: 1390 couples



# Stand alone VCT site: Vaccine Division (42% HIV+)



## VCT Results by Gender



52% of women & 34% of men are HIV+

# Sexual Risk Behaviours of VCT attendees

**TABLE 2.** Sexual partnership risk behaviors in the previous 6 months (n = 197)

Participants reporting at least one of the following:	Men (%) (n = 92)	Women (%) (n = 105)	<i>p</i>
A steady sex partner <sup>a</sup>	82.0	94.8	0.0054
A casual sex partner <sup>a</sup>	49.0	17.7	< 0.0001
An anonymous sex partner <sup>a</sup>	15.0	4.2	0.0104
A casual or anonymous sex partner <sup>a</sup>	56.0	21.9	< 0.0001
A one-night stand	31.0	7.2	< 0.0001
A partner with an age difference of 15 years or greater <sup>a</sup>	8.3	2.1	0.10
A partner of the same gender	2.0	7.2	< 0.0001
A partner who spends nights away from home for work <sup>a</sup>	18.4	27.7	0.13
A partner with known HIV <sup>a</sup>	7.5	3.3	0.33
A partner with known or suspected HIV <sup>a</sup>	27.7	8.9	0.0010

<sup>a</sup> Sample size slightly less than listed due to missing data

Source: Mesesan K, et al, AIDS Vaccine, 2005

# Project accept

PERINATAL HIV RESEARCH UNIT



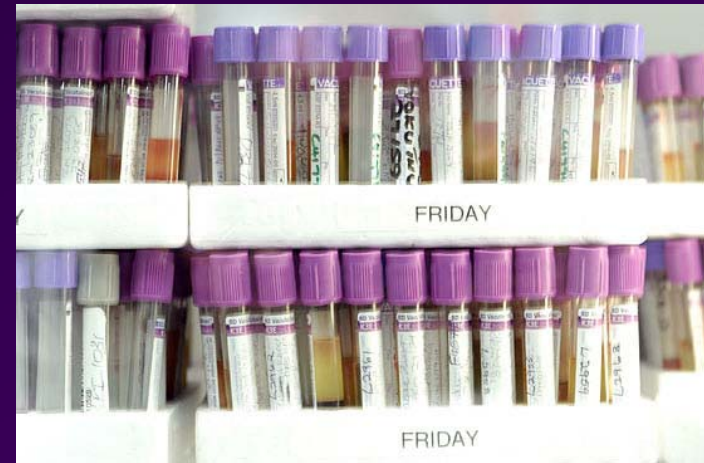




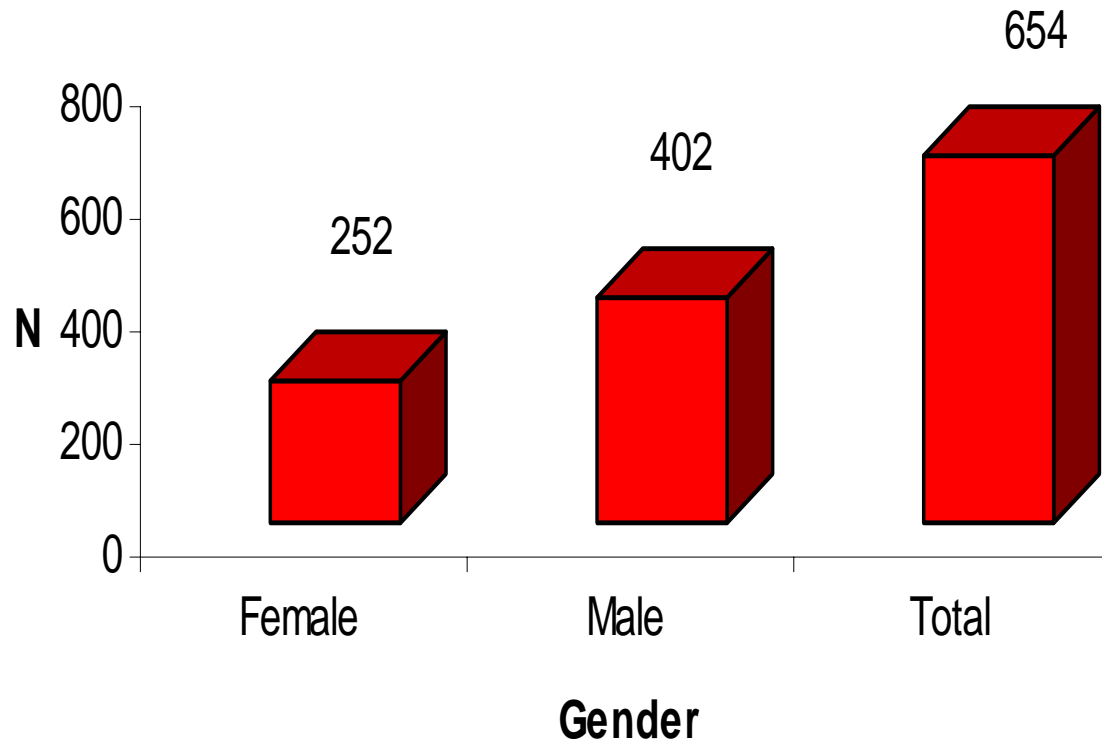


# HIV Testing

- Parallel testing – First Response, Pareekshak
- ELISA and Capillus – indeterminate results
- Anonymous testing is conducted – participant are provided with unique id numbers

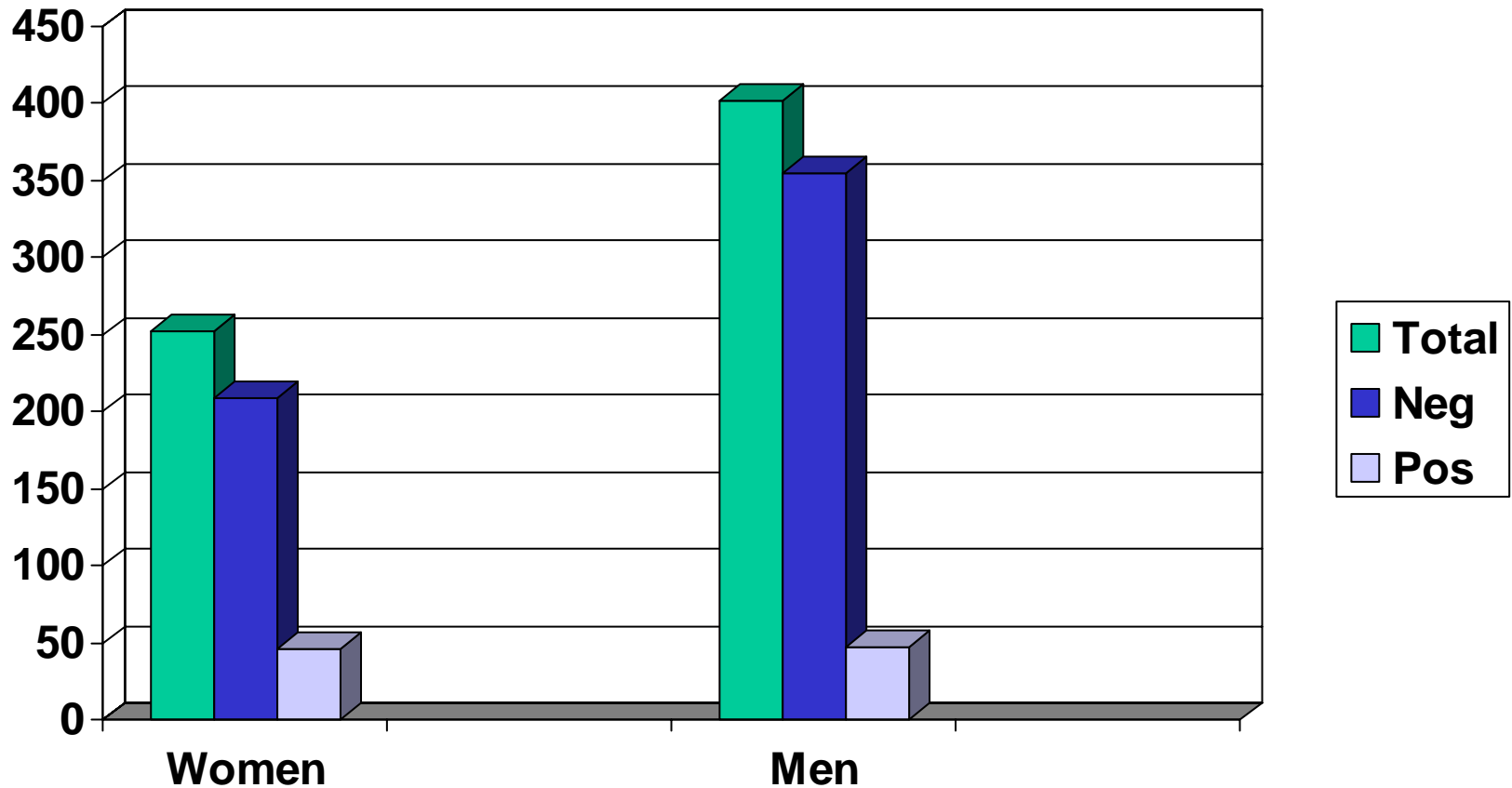


**Figure 1: Mobile VCT service utilisation by gender**



More males (61%) received mobile-VCT as compared to females

# Mobile VCT



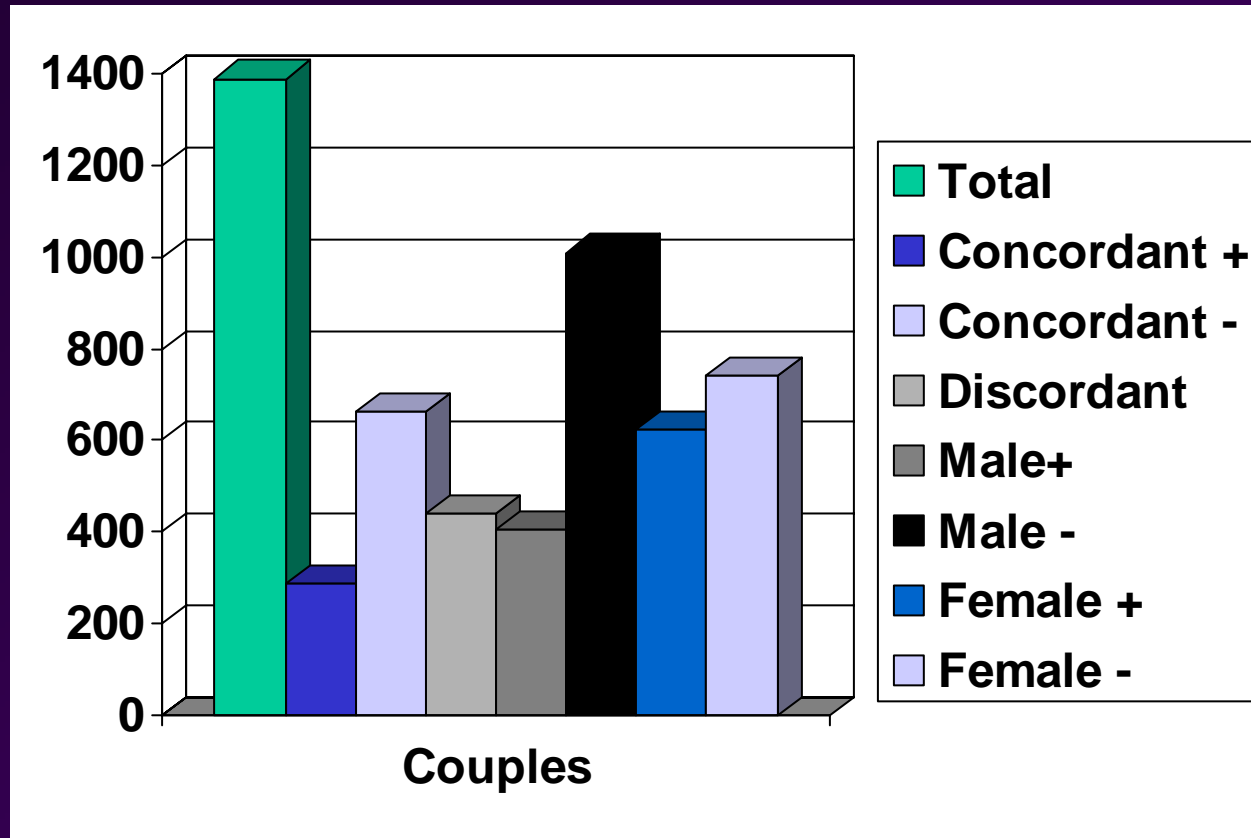
18% of women & 12% of men are HIV+

# Couple Counselling

- Counselling together
- Tested together
- Results together



# Couple Counselling: Tswarisanang



32% of couples were discordant; 20% were concordant positives

# Soweto MTCT programme

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- >30,000 deliveries per year
- HIV prevalence in pregnant women has risen from 3 in 1000 in 1988 to more than 3 in 10 in 2005
- Only 5% of women do not attend antenatal care
- PPVCT: 34% HIV+
- No access to ARV at present outside of research trials





